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Remarks of

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Chairman,

Subcommittee on Health and the Environment

before

the First National Conference on Continuity of Care

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I am glad to be able to join you today. I'd like to thank Mary Ann Klis for arranging for me to be here.

I'm especially pleased to take part in this conference because your definition of Continuity of Care summarizes what I think health policy should be all about:

> providing patients with comprehensive, non-fragmented health care--providing them with the highest quality of health care at any point of their ... need, or having patients in the right place at the right time at the right dollar cost.

Unfortunately, since the Reagan Administration has taken over, we don't hear very much about issues like "patients" or "comprehensive care" or "quality." Instead we hear only about co-payments and deductibles and liens. The Administration has made this a time of legislation by statistics, not issues or people.

The Administration has not been concerned with continuity of care. Instead, two critical factors have been driving the development of health legislation, and indeed all domestic policies, during this Congress.

- First, the Reagan Administration's commitment to slash spending in health and social programs; and

- Second, the Congressional Budget Process.

The Reagan Administration assumed office more than 19 months ago. Their basic objective in health programs is simple and harsh -- they want to cut spending and benefits. That should come as no surprise because the President has advocated dramatic program cutbacks for many years. However, I highlight it because the rhetoric flows quite freely and tends to obscure this underlying theme. You hear a great deal about competition, a social safety net, deficits, and the new federalism.

But the unfortunate reality is a series of deep program cuts -- $14 billion in Medicare and Medicaid cuts in the tax bill, and billions more to be proposed by the President next year. If you want to understand what is going on in health legislation, whether it be competition, New Federalism, or the Budget itself, you have to keep that basic objective in mind -- the Administration wants to cut these programs, and is generating enormous pressure on the congress to do so.

The second important factor is the Congressional Budget process. This has become the principal vehicle for getting legislation through the Congress, so you need to understand it in order to understand and participate fully in the development of health legislation. Let me briefly walk you through the basic steps in this process:

o In January or February, the President submits the Administration's budget proposals to the Congress;

o In March, the Authorizing Committees with jurisdiction over programs submit budgetary recommendations to the Budget Committee. For example, my Subcommittee makes recommendations for public health programs, Medicaid and Medicare Part B.

o The Budget Committee then reviews all of these recommendations, and in April reports their recommendations for the First Concurrent Resolution on the Budget. This Resolution sets overall revenue, spending and deficit targets, and provides spending levels for specific functional areas such as health.

o The Congress then debates this and alternative resolutions. As more people become aware of the importance of this resolution, more and more attention focuses on this step in the process. For example, this year there were a total of 7 resolutions with as many as 68 amendments to each in our first budget debate. Following that, in June, an Administration-backed Budget Resolution did finally pass.

o The Budget process originally envisioned that this First Resolution would simply set goals and targets for the Authorizing Committees, and would be subject to revisions in a Second Resolution in September. However, the Administration succeeded last year and this year in making the first resolution binding -- requiring that cuts be made. Thus, this resolution has become the critical factor driving the legislative process for the rest of the year.

The Administration's success in making this First Resolution binding has dramatically skewed our decision-making. The resolution is debated in multi-billion dollar terms that few can even comprehend. There is little or no understanding of the impact on particular people and programs. However, once passed, it has the effect of forcing cuts in those programs in order to meet the abstract totals.

The process has the appearance of rigor because budgetary spending and savings all seem to be quantified. But it is a false rigor. Only short-term Federal spending is counted -- discouraging investments in cost-effective alternatives and encouraging shifts of spending to states, providers, or patients. In addition, only some kinds of issues are quantified. The fact that we spend a dollar under a Federal program is rigorously counted. But equally important facts about underserved populations and uncovered services are somehow not considered as rigorously.

The result is that we develop targets that few understand, and then must make harmful program cuts to meet those targets. I urge you to follow this process closely next year and make your views known to the Budget Committees and the Congress before those resolutions are developed.

Let me turn now to some of the specific issues that we have been dealing with.

First, we have just enacted in the tax bill substantial Medicare and Medicaid cuts.

o The president originally proposed FY 1983 cuts of $4.6 billion in his budget proposal.

o While many of us opposed these harsh cuts, the Budget Resolution finally adopted required cuts of almost $3.8 billion.

o The final legislation just passed cut the programs by $3.1 billion.

In developing that package, we did everthing we could to minimize Medicare cuts that would shift costs directly to beneficiaries, and to limit the cuts in the Medicaid program.

As you know, Medicaid was cut substantially last year, and the fiscal pressure on States has forced program cuts in many areas.

The President's Budget originally included some $2.2 billion in additional Medicaid cuts. This included the "three-percent solution" of cutting matching rates 3 percentage points for so-called optional eligibles and benefits, including most of the institutional and home-based long term care services that are so vital to your efforts. I am pleased to report that we succeeded in defeating that short-sighted policy, but I caution you to follow the President's new budget proposals, which will undoubtedly include similar cuts once again.

But let me turn for a moment to some of the specific continuing care issues that we have been working on. I think that there is a growing awareness that our Nation's health financing and delivery systems have overemphasized inpatient hospital care and underemphasized and underfunded the alternatives. I can't tell you that we know enought to resolve the problem, but we have taken some very positive steps that highlight that growing awareness.

In fact, the General Accounting Office--the Congress's auditing agency--recently did a study at my request and concluded that, the Nation's nursing home patients are generally more seriously ill than in the past, leading us to understand that programs to encourage non-institutional care have begun to have some impact.

Much of that change has come about as a result of your work and in spite of institutional incentives.

But in the past few years we have put together several pieces of legislation that will, I hope, help you to provide patients with the right care at the right time.

As I'm sure many of you know, last year--in the midst of budget cutting--we extended Medicaid coverage to include waivers for States seeking to cover home- and community-based services. This provision allows States to package a broad array of services in an effort to assure care in the most appropriate setting.

Over the years, there have been a number of projects for which States could apply for waivers of regulations. Without a doubt, this one has been the most overwhelmingly popular: At last count, 31 States have submitted requests in the last year and 18 waivers have been granted. We will be following our experience under those waivers closely. I hope we will learn more about how we can address the issue in Medicaid and Medicare in the future.

Second, I would note that we have funded a major demonstration on long-term care channelling projects. These projects are designed to show us more about how we can structure systems--administrative, financial, and delivery--to get patients the appropriate level of care.

Third, you may be interested in the hospice provisions of the Medicare legislation that we passed as part of the tax bill this summer. That bill included a section allowing Medicare beneficiaries to elect to receive hospice care and to have the Federal government reimburse for the cost of those services.

Finally, I would alert you to a draft regulatory proposal within the Department of Health and Human Services. As you know, the Administration has gone to great lengths to weaken the protections of current nursing home regulation. We have, for the time being, prevented the White House from de-regulating nursing homes.

But there is now within the Department a draft proposal to go on to weaken standards for hospital social service departments. Present law does not require that hospitals have such social service units, although most do so as part of their routine services. The proposal would remove all standards for these departments. I'm sure that many of you have some interest in this regulation and I am equally sure that many groups will come to the Congress soon to slow or accelerate the changes. I look forward to hearing some of your advice on the proposal.

The final areas I want to bring up with you are the so-called "New Federalism" and "Pro-Competition" initiatives. These are areas which have been accompanied by the greatest amount of rhetoric. However, you need to test that rhetoric against the reality of program cuts that I mentioned at the beginning of my talk -- the Reagan Administration's underlying objective to cut program spending.

The New Federalism was announced with great fanfare in the State of the Union address. But the Budget accompanying that speech reflected only deep cuts. I for one have always advocated a stronger Federal role in Medicaid, but two huge problems remain with this proposal:

o First, we simply cannot abrogate our responsibilities for income maintenance programs, and grant programs like maternal and child health, as part of this initiative, despite our desire to federalize Medicaid.

o Second, despite the positive rhetoric, the President's apparent definition of federalizing Medicaid is quite different from what you, I, or the States could accept.

In their most recent proposal, they have apparently defined federalized Medicaid as

-- excluding the so-called optional services, such as home and community based services;

-- excluding long-term care, which would be financed with a block grant; and

-- excluding the medically needy.

Such a proposal would further fragment the health care system and would make things even more difficult for discharge planning than they already are.

-- Hospital care and some skilled nursing and home health care would be financed under the Federal program

-- Other long-term care would be financed under the State program. Funds under such programs would be inevitably limited and alternative sources would be severely constrained.

And the incentives of such a system do not bear examination well.

-- The Federal program would move people out of hospitals and skilled nursing facilities quickly because that would save them money.

-- Meanwhile the State long-term care program would do exactly the opposite, because the people in community alternatives would <u>cost</u> the State money. Even if such alternatives were to cost the total health system less, they would mean higher <u>State</u> spending. Very few governors will stay enthusiastic for long.

In such a situation, the continuity of care of all patients would suffer tremendously as people are shunted from one system to another, in search of someone who can pay.

It is a sham to call that a federalized Medicaid program, and most of those involved in reviewing the proposals seem to agree. The Governors have rejected the proposals, and even the President's allies in the Senate have been harshly critical. Again, however, I urge you to continue to follow this issue, because they will undoubtedly continue efforts to cut back on these programs through initiatives like this one.

I also want to mention the so-called "pro-competition" initiative. This has been promised as the great solution to all of our problems for almost two years years now. (You might remember that many people said the same things about health planning back in 1974). But so far the Administration has only tried to repeal planning and still has not sent us any draft legislation on competition.

I will tell you that I have always favored introducing more competitive pressures into the health system, but once again we have a problem of definition. The President seems to define "competition" as a cut in coverage under public and private insurance programs.

I reject that definition.

Efforts such as yours are where the benefits of real competition are found. The definition of your goal puts it well: "having patients in the <u>right place</u>, at the <u>right time</u> at the <u>right dollar cost</u>." That's what a competitive market is all about.

But the proposals that are called competitive by the White House just won't get us to that point. The obvious initial impact willl be increased cost-sharing and reduced coverage.

And the Congressional Budget Office estimates that those coverage changes would not be in the expensive inpatient hospital services. Those services would be covered by everyone, to one degree or another.

Instead the non-hospital services would be cut. As you know, many of these alternatives--including nursing home care--are already far too limited. Those limitations are a large part of the problem we confront in our efforts to assure more continuity of care. The supposedly "competitive proposals" that would lead to further limits in alternatives are foolish and counterproductive.

I would like to thank you once again for inviting me, and I look forward to working with you in the future. I will be happy to answer any questions you may have.